

Prescriber Criteria Form
Tadalafil BPH 2026 PA Fax 6552-A v1 010126.docx
Cialis 2.5 mg, 5 mg Only (tadalafil 2.5 mg, 5 mg only), Chewtadzy 5 mg (tadalafil chewable 5 mg)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact
CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are
met, we will authorize the coverage of Tadalafil BPH.

Drug Name (select from list of drugs shown):

Patient Name:

Patient ID:

Patient DOB:

Patient Phone:

Prescriber Name:

Prescriber Address:

City:

State:

Zip:

Prescriber Phone:

Prescriber Fax:

Diagnosis:

ICD Code(s):

Please circle the appropriate answer for each question.

1	Is the requested drug being prescribed to treat ONLY erectile dysfunction? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of benign prostatic hyperplasia (BPH)? [If no, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to both of the following: A) alpha blocker, B) 5-alpha reductase inhibitor (5-ARI)?	Yes	No

Comments:

By signing this form, I attest that the information provided is accurate and true as of this date and that the
documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:** _____